Meaningful Use Workgroup
Subgroup #1 – Improve Quality
Transcript
May 29, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good afternoon, everyone. Sorry for a bit of a late start today. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #1 Improve Quality, Safety, Efficiency and Reduce Health Disparities.

This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I will quickly go through roll and then ask for any staff members to also identify themselves. David Bates?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Charlene Underwood? Charlene, I know you're there.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm here. Hi.

MacKenzie Robertson – Office of the National Coordinator

Marty Fattig? Michael Barr? Neil Calman? David Lansky? Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. Eva Powell? Are there any other workgroup members on the line or any staff members on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay, David, I'll turn it over to you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Thank you, MacKenzie. So, what we've been doing is we first talked about some general principles. Then, on the last call, we worked our way most of the way through this list of measures. The aim today will be to go through—basically to think through if anybody has additional comments on those and then we're planning to spend most of the time today brainstorming about potential Stage Three objectives, ones that are not already covered by what we've talked about. So, let me stop there. Paul, thoughts or comments?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No. sounds good.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Charlene, anything?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm good. I'll stay off mute. It's quiet here.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm just trying to get my computer to boot and my password has just changed. So—

Michelle Nelson – Office of the National Coordinator

David, while you're waiting for your computer to boot, do you want me to lead where we left off and we can ...?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That would be great.

Michelle Nelson – Office of the National Coordinator

So, I think we are on generating lists of patients by specific conditions.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right, which is—I'm scrolling through and looking for that.

Michelle Nelson – Office of the National Coordinator

It's on page 13, the very top ....

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Thank you. So, we didn't talk through this one then. So, let's go through these specific ones and then we'll go into the more generic issues. So, here the Stage One rule was that you should be able to generate lists of patients. Stage Two, you should be able to generate lists of multiple specific conditions. Then, the NPRM pretty much paralleled that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But they didn't include the multiple. That was our comment back.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes. So, I think we definitely should ask for multiple at this point. Don't you, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes. You're talking about in Stage Three?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I wonder if we start ... So, it lists by ... tend to be retrospective. It would be wonderful to have things much more in the stage of the provider at the time. So, thinking about it more like a "dashboard" rather than a retrospective list. That might be one. Did we cover this before, or was it on a different call?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think it was a different call. I don't think we got—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That might have been care coordination or something.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes, I think it was probably care coordination.

Michelle Nelson – Office of the National Coordinator

Paul, the other thing to think about here possibly, we've got lists. This gets a little slippery, but it's like keeping, if you will, registries of your diabetic patients, those patients that you've discharged and you've got on watch because you don't want them to return. So, do we change the bar a little bit?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think that's what I'm referring to. So, think about as you log in and there are—it should be this too, but as you log in, I'd like to know how am I ... with respect to high priorities for our organization or for me today. So, there's that one kind of overview where outreach is an important part and there's another of, let's say I'm seeing some more diabetes. How is this person doing, and how is this person doing with respect to all the things that pertain to this individual and how are the—what guidelines—well, I might be confusing things here.

So, let's just stick with lists for right now. So, more the dashboard, how am I doing on my high-priority conditions? It could be high-priority conditions for my organization or locale or for me personally? So, it's almost like a mini huddle with yourself. Hey, what can I do today to improve things just one-step?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Should we make it a separate thing?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And do we link them somehow?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, I think they should definitely be linked, and I think that the functionality is key. The only question is sort of how to refer to it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think this is one of the most important things that a record should be able to do from my perspective.

W

This is like the crossover with managing populations, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I'm wondering if—in the past we have used terms like replace or consolidated. You might leave that. So, we've had a track record of well, the computer has to do more than just tell me about one patient. It's got to start giving me lists of people and then migrate it to populations. So, we show its heritage of the list functionality, but for Stage Three, we call it something different like dashboard or something and link it back so that we see that we've been on that road map, but we're emphasizing something different but it didn't come out of nowhere and we have not dropped lists per se.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

You still need the lists and you need to be able to do it for individual conditions but also for multiple conditions, but then, you also need a dashboard functionality.

W

I'd agree because there's the dashboard piece. There's both aspects of it. We provide dashboard functionality in terms of just alerts and their patients and that kind of stuff, but it's also then you still need a process to manage your population, to step back a little bit too, so two pieces of it. You want it in context of taking care of the patient but also in context of managing your panels and that type of thing.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. I'm scrolling up and scrolling down and trying to see if we talked about that someplace else but I think—

W

I know we've talked about it. I just don't remember where.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But I don't think we have a requirement for it, at least that I can locate.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No. You have a better memory .... Michelle, it seems like this has come up somewhere. My guess would be care coordination. I don't think we've wanted that correct. Then, two, have we come up with a requirement around this?

Michelle Nelson – Office of the National Coordinator

Not that I recall yet, Paul.

W

In our care coordination listening session the other day, clearly they're using this kind of functionality to identify patients who they are coordinating the care for, right? Identify them, track them and—

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

W

So, there's going to be overlap across all these workgroups that we're going to have to come back and reconcile. That probably shouldn't stop us.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

May I ask one off-topic question here to Michelle. As we pull these different recommendations from the different subgroups, is there a way to reconcile some of this stuff ahead of presenting it back to the Meaningful Use Workgroup?

Michelle Nelson – Office of the National Coordinator

Sure. I think this group is one group that's really actually sat down and really talked about what the measures will be for history, but as we get closer to the other groups, I'll help do that.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Thanks so much. So, I like Paul's notion of linking. You really need an interactive registry tool, which lets you manage population.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's a good function because most people are going to put out a list and then everybody's going to have to go chasing down yet another screen etc., but the notion that you just click on it, and then, get right to that person's chart would be wonderful to spell out. Is that what you meant?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It's almost like the imaging functionality that's just appearing in State Two, which is you just click on it and you get right to that image, same thing.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So, the next one is the reminders. In Stage One, we said preventive or followup reminders to 20%. We then, in State Two, recommended that 10% of patients be sent a clinical reminder. The NPRM said you should use information to identify patients who should receive reminders, and then, more than 10% of unique patients who've had an office visit within the 24 months were sent a reminder per patient preference.

So, that I think is good, but the preference thing adds another step. Ten percent is pretty low. I think we could clearly go much higher, right?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, Stage One was 20% of people over 65 or younger than 5 that were, I think, out of your entire population. The proposed thing that we did was to change that to 10%, just try to figure out—keep the whole population and lower the percent.

The NPRM, looks like the measure is people who have been seen. That's a different measure. I don't know—it's 24 months. I'm sorry. I apologize. It is the same. They just spelled out what active meant.

Michelle Nelson – Office of the National Coordinator

Right.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, what do you think? Is this something where we could go quite a bit higher?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, should we tie it more towards—it's a little bit like the previous requirement. The objective is to manage your population.

W

It all starts to fall under active, like under our population health stuff, it's the broad stuff, but this is the individual provider doing that.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, I'm a little reluctant to retire it. This is population health, but this is the preventive part of it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, this is suggesting recurring. I'm trying to figure out a different—just like the one above, we attack the same problem that is managing a population, but we progress from lists to dashboards which is essentially retrospective to prospective, and here, could we do something like that? Instead of only creating the function of sending out context-specific reminders, can we move toward satisfying some population health priority? Do you see what I'm saying? Is there a way to—is there a conceptual change?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm trying to figure out what that might be. It seems to me like what we're after here is that we want people who are eligible for their mammogram or their pap or whatever to be getting notified about that or if they've had a colonoscopy and they had some issue in the past that they get notified about that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, this is fairly generic and it was sort of designed that way mainly to get the functionality. Can it be more focused on priorities? So, this is sort of an across-the-board outreach. Could it be honed to be—and I'm not suggesting, I'm just asking is there a different approach, if that makes sense.

Could it be honed to be half a dashboard. You can't have a dashboard for every health condition or prevention. You have certain .... Can your outreach also be prioritized? So, that's a question to ask ourselves.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, this is Michael Barr. I joined late. I apologize, David. Just one question for you—what about in terms—I like the idea of focusing. What about with respect to the conditions for which they start reporting clinical quality measures, having some reminders associated with those conditions?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think that's where it's going. So, let's say if you want to ... heart, then your dashboard would have the relevant things and perhaps your outreach is as well and of course so does your clinical position for when they're in front of you.

Michael Barr – American College of Physicians – Vice President, PA&I

Right. Because I think most clinicians will do the preventative stuff based upon the existing metric, and I hear you and I agree with you and David and Charlene with respect to moving towards condition-focused around the patient separate in part from the population initiatives will go, but this is on a per patient kind of—you have this chronic condition for which I am going to be reporting clinical quality measures. I need to be reaching out to you with reminders.

W

You know how sometimes, they're just checking the box and it just starts to tie it together too.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

You could also think of dashboards, okay, I see my dashboard so I know the organization or the ... accepted the priority. I see where I'm falling short. Now, I would like to activate some reminders in the following way.

I could say, let me see. Let's try, flu vacs is a priority this year. I have a pool of outreach kind of messages and I could tweak it based on which high-risk patients do I want to address first. I could say either the seniors or the kids or whatever it is and I sort of—

Michael Barr – American College of Physicians – Vice President, PA&I

But don't you want your flu vacs ones to go out to everybody every year?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, I just tried to find something where I could tweak it.

Michael Barr – American College of Physicians – Vice President, PA&I

There's a whole base—I'm thinking of this more in targeting the whole base of things that you should be sending out for everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's the approach we have here versus do we want to do priority-sensitive outreach and is it the same. Are they separate, or do we not need the latter?

Michael Barr – American College of Physicians – Vice President, PA&I

Well, I think that they're separate personally. I want to have one thing that's focused on prevention. We're a long ways from having all providers send out messages about mammograms and pap smears and Pneumovacs and flu shots and that's what I'm thinking about.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, that speaks to what we have in front of us.

Michael Barr – American College of Physicians – Vice President, PA&I

It does. The number isn't as high as I would like.

W

You want that postcard in the mail that says, come in, you've got to show up. I know it's not a postcard anymore.

Michael Barr – American College of Physicians – Vice President, PA&I

Here are the five things that we're thinking about for you.

W

Yes. You're still managing a population though to some extent though.

Michael Barr – American College of Physicians – Vice President, PA&I

You are. The tricky thing from my perspective is if you don't know how many of your patients actually are eligible for one or more of these things. There are a lot of people that will have nothing that they're eligible for especially if they're young, if they're 20 to 50, but once you're 50, there's a lot of stuff that you're eligible for.

Michelle Nelson – Office of the National Coordinator

You're right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, David, so how would you know? It's almost like the dashboard, the previous objective dashboard, talks about priority conditions. You might want to know where are some of my shortcomings from a prevention point of view and how can I best work on that.

So, let's say you were short of flu vacs. Well, that probably would be a postcard or you could alternatively say or there might be something more personal outreach either from electronic messages that go out from you or calls from your MA or my high-risk elderly flu vacs. Do you see what I'm saying?

I'm trying to line up the reports you're getting with what facilitates action is it easy for me to react with? So, what we talked about before was a list. Typically, they're going to be condition specific or disease specific, and now, there's another area, and you're pointing out the prevention and you would like similar reports though. You'd like a similar dashboard and then you could decide what method of your library of things you could do, how to reach out. So, I wonder if there are—I'm just still trying to find the migration. Rather than just tweaking all the numbers and thresholds, can we get more and more towards the population management and improving outcomes and what do we need?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I hate to add items.

W

Well, this is the time.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

... items.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right, exactly. I think you need different things for prevention. In addition, you need separate people with chronic diseases. The targeted outreach, which you're talking about, Paul, I think is more relevant to the people with the chronic diseases.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

The prevention could also be—it's your way of saying how am I going to spend my time. You're looking at your things. You're looking at your flu vacs. You're looking at your colonoscopy. You're looking at your smoking, and you go, where do I want to spend my time. You could say I want to spend my time on colonoscopies and then decide here's things I could do to—I could activate to try to reach out. It's getting the individuals and organizations tools to go figure out how to act on their priorities.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, what I want is for our system to basically include approaches that deal with a whole set of stuff like the preventive stuff and then frees the doctor up to think a little more about some other things that are more discretionary. I think it's better if the doctors don't have to worry a lot about who gets their flu shots, but that's just sort of happening as part of the machine.

W

So, what I hear David saying is like we should probably just put in there preventative reminders. That starts to get pretty prescriptive.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, it does help to do the outreach. So, I'm okay with preventative outreach, but I was thinking of increasing the number and say going to 50% of eligible patients or something like that. The question then is who's eligible.

Well, the nice thing about low percent is one, you get the functionality in there anyways. Two, you make—even to accomplish some modest number, let's say 30%, the organization has to train people to use these things and by avoiding the high number, then you don't have all of the questions about who and who not. It just starts getting into gaming.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. Michael, what are you hearing from people about this area?

Michael Barr – American College of Physicians – Vice President, PA&I

The question is whether they're using it or not at this point honestly, but I think the direction you're describing sounds very reasonable. I agree, as I said before, maintaining the lower threshold just to get people using it. I would emphasize though using this type of stuff for beyond preventative care around specific conditions that are important to the particular practice.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, I think we should have two separate ones about this. So, one about prevention and then a second one just the one that Michael said which dovetails well with what Paul said.

Michael Barr – American College of Physicians – Vice President, PA&I

I think the threshold for the second part should also be relatively low. Again, we want to get people using this and experimenting with it to do good.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

David, you said two objectives or two ....?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Two objectives, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, one is conditions presenting and one's prevention.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

One's focused on prevention. The second is condition specific.

Michael Barr – American College of Physicians – Vice President, PA&I

On the condition specific, just to reiterate, I think what I said earlier, but I'm not 100% sure, it should be the conditions which the practice has decided are important for them and are choosing to report on the CQMs.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think that makes a lot of sense. Michelle, do you got that?

Michelle Nelson – Office of the National Coordinator

I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, the concept here is instead of prescribing some conditions, you prescribe only a number and then let the practices and hospitals decide what's important to them.

Michael Barr – American College of Physicians – Vice President, PA&I

Exactly. It's very similar to some degree in the medical home recognition criteria where they say you have to adopt evidence-based guidelines for three clinical conditions and ... categories, preventive chronic care, behavioral health kind of issues without specifying the actual conditions and letting the practice choose among those. So, I'd even argue for even less categorization than NCQA does, but allowing the practice to a certain number of them. I don't know what the number should be, but get them starting to use the technology to reach out to those folks with conditions.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

For the prevention, there should be exclusions for special ones.

W

Right.

Michael Barr – American College of Physicians – Vice President, PA&I

Although you could say there are some things where a specialist might be going after, but it would be more condition specific. You're right. So, if it's something that a patient agrees to a certain, that's preventative care. That's prevention, but most ....

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I will make the argument at least what ... has said is that they do look at the—it doesn't prescribe that the physician does it, but in every encounter, somebody is looking at prevention. Then, they do have started a ... video where, I don't know, it was an ENT or allergist, probably a clerk who picked up something that turned out to be a breast cancer, picked up being overdue for a mammography.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't want to burden off specialists with looking at this. Are we ready to move onto the—

W

Just as a tie—this again ties to I forget what we ended up doing in clinical decision support, but all this links together, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

W

I forget what we did there.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

It definitely should. I agree. I can't remember exactly what we did either. So, the next one focuses on medication orders and we said there that we recommended that med orders be automatically tracked via the eMar and the—I think this is also what the NPRM says just in more words. What do we want to do here, maybe increase the threshold? Before we said 10%, I think it should be a lot more than that by Stage Three.

W

I agree. It's pretty robustly deployed now.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes. Once you start doing it, you're doing it. Should we say 70% or something?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Or maybe 50?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We're in the high 90s. It's sort of once you flip the switch on eMar.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think the challenge is not so much how many things are done as how they are done. The unintended consequence of putting a bunch of patient labels on your med cart and that kind of stuff, if there was a way to get how you're doing it in a way that does improve identification and avoid errors.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. That's harder.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It would almost be better to have something that direction that a low threshold than just numbers.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, I don't know how to put—we've studied this a lot, but I don't know how to define that in a way that we could get people to attest to in a reasonable way.

W

Paul, what are you looking for?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Some of the challenges that may come with positive ID that lets' say either the gown covers it or the ... so people end up having workarounds for this like putting all the IDs on the med cart and just click the one that you think you're giving it to. You still score on the percent that have been done, but you actually didn't worry about addressing the intended benefits. Do you see what I'm saying?

W

Safety.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, is there a better way? I wonder if there's a report. I'm just thinking out loud. Instead of looking just at whether you reported this electronically, are you sensitized to errors that are made and then act on those? Do you see where I'm headed?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. So, tracking of mismatches, that sort of thing.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right. It's actually do you first know about it and then do you design something to act on it.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Tracking and responding to errors and issues that are ....

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right. You might think to improve in the number of errors by reducing the number of errors of whatever you discover.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That gets really hard.

W

A lot of systems are doing that today. I know they track—they get their reports out, the number of wrong patients and that kind of stuff and then they and how many are legit versus not legit and that kind of stuff. So, that's kind of—I know for a lot of the systems current practice, so they do that analysis. The hardest thing they have is they can't figure out the terminology to make a comparative process ....

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, maybe that's what we could help with.

W

What David said. It's like it actually gets to those measures is really ....

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's where we might be able to help, right?

W

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

There's a reason that's a challenge, right? I think just requiring the ability to track those and then respond to them in an ongoing way with .... That's what our IOM Committee said.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, how do we write it that way?

W

I know you can demonstrate the kind of thing like—other systems, I'm sure do this too. You produce that report, right? I don't have this at my fingertips, but clearly if you've got a wrong patient—but there are numbers that these systems produce and report and you just want the report, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes. The fact that people are doing this already means they recognize the problem and they recognize that they want to fix it. You could almost go back to probably one of your papers, David, on the classification of med errors and say can you produce reports of the number you're making in each of these groups.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Otherwise, this is just a process measure. Do they electronically do the five right whether or not it really is this issue with this patient?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, just getting this in place is a big deal. Are we ready to move onto the next one?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, what have we agreed on though?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, I think on asking for the capability to generate reports of the various classes of errors and then acting on those.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, we might want to enumerate that.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We could do some looking offline.

W

Right. Because we can certainly share what we produced, but then, if we can make it more generic, that's fine.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think that they're mostly the same.

W

I think they're the same too. Everyone gets their ... literature.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

The next one is on incorporating imaging results and information into certified electronic technology. This basically says that your x-rays can be seen through the record. Now, here we recommended a 10% threshold, and we're concerned about the measure requiring standing images for 10%, a lot of concern here about the small practices.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It just follows the rule of once you get ..., nobody's going to stand in your way of using the template you've created. We just didn't want to be overly optimistic for the rural communities.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm concerned about that. Michael, are you hearing anything about that?

Michael Barr – American College of Physicians – Vice President, PA&I

Just what you just stated, David, and obviously it remains to be seen how successful they will be if this is kept for Stage Two.

W

Well, it's proposed as menu, right? I think it's proposed as menu for Stage Two.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't know. Does anybody know about that?

Michelle Nelson – Office of the National Coordinator

Yes, it's menu.

Michael Barr – American College of Physicians – Vice President, PA&I

It says menu right there, menu measure.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm not seeing where it says menu.

Michael Barr – American College of Physicians – Vice President, PA&I

Right under objective.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

W

The feedback we're getting is more or less prescription about how it's done because in some cases, it's the shared resource in a community and all that kind of stuff, more provisions for the docs to see it, but again, it depends what they finally say, I think.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, do we want to do anything different for Stage Three?

Michael Barr – American College of Physicians – Vice President, PA&I

This is Michael. I would say in the absence of any data to leave it alone. As Paul said, once they start doing it, it'll flow by itself. So, changing the threshold is probably not going to make a huge difference.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I agree with that. Everybody okay with that?

Michelle Nelson – Office of the National Coordinator

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. Next one is a history of structured data, which we list as a menu item.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, the question is whether anybody's working on making this standard.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

There are a lot of them floating around out there.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think it should become one for a few specific family history items, but it's only a limited set. Didn't we talk about this someplace else? It's really breast, colon, breast and colon cancers are the most important.

W

I think that ultimately we want to feed it for our population health teams, right, our registries?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes. On our dashboards.

W

Yes. So, the capability you want is through that capturing the history, you want to be able to populate your dashboards for whatever conditions you're trying to manage, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. I'm wondering if we should focus, for example, specifically on high-priority conditions.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It could be different priorities for different groups though.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

It could be, but it's still—the ones that change what you should do the most are breast and colon.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, let's say somebody is doing really well, that somebody has a comprehensive breast center and they do very well.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes, so that's good. They're way above the bar. Are there other family history issues that should be high on the list here? The other things are things like glaucoma. An ophthalmologist should be asking about glaucoma.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Quick question—was there a frequency associated with the recording of the patient's family history?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Not that I can see.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Not on the short abbreviated one, but I'm looking at our comments and our comments referenced something about an annual or within the reporting period update on the family history.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That seems too much to me.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Exactly. That's why—since it's not specified in the short, you may want to go back to the proposed rule or obviously the final one.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think it should be a one-time thing or maybe a five-year update or something. Other thoughts about that?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, I like getting more discrete as to the purpose of what we're trying to do with it.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think I'm heading towards where Charlene saying, like could we measure if used in CDS? So, if you pick first figure out how to standardize some high-priority family history data and then use it to modify some projected measure like CDS or even outreach.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

For example, you could use the family history of colon cancer or your ... to affect which would include of course the date of your instance to affect your colonoscopy screening. That's the outcome we want, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Instead of just prescribing you've got to do this, this all becomes check boxing and process, but if we can make sure—first of all, we haven't even made sure that every CDS intervention can take into account family histories. In fact, probably to date, most of them can't. So, could we move that functionality along as well as being part of your preventive outreach?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Charlene, we routinely consider this in our decision support, although I have to say that the number ones for which family history is relevant is pretty modest.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, you're about to not consider it anymore.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What I see in most of these systems, this is just not kind of as connected. Like you've collected a family history but it doesn't trigger anything. Then, it's all up to the doctor to keep it all, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

It should definitely be linked to the decision support. Why don't we add Paul's thing about it being linked to the decision support, and you mentioned one other thing too besides the decision support?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Outreach. So, I wonder if really this is one, it's to drive standards. That's one of our biggest problems. Then, it's used—remember how we had in Stage One, there was a menu item about one of them had to be public health? It's sort of like in our CDS and outreach, the lists and stuff, may be to include family history. So, we can do that without ....

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Then, we're starting to link it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

One, that'll create the certification criteria that I don't think commercial systems largely have this and then two, start stimulating the kinds of things you'd want to—the kind of ways you would want to use family history. Then, that goes back to begging the question about the standards.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I guess you don't have to have standards to make it useful within your organization.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

There are some emerging standards for this. So, I would say that they're not great.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Does ICD-10 have or SNOMED have history in these important ones?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm pretty sure it does, but there's maybe a bit more.

W

I would think SNOMED would, but again it depends if it's too discrete. I don't know that because again, you're talking about family history and you have no idea which breast cancer is in your history, what they had.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's not even—actually ... has some family history stuff.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm pretty sure SNOMED does because I know that we have our family history stuff mapped.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I wonder if this becomes privy and SNOMED I believe is the diagnosis and problem list.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

The family history is recorded often on a separate place in the practice. I think we should specifically ask for it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, what do we think? We need some homework. Does SNOMED have family history, a class for family history? If so, is that—I guess somebody would have answered this a long time ago. Is that a reasonable standard?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, I'm pretty sure that it does have a standard for it, but I have no idea whether or not it's reasonable.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, how can we do homework on this?

Michelle Nelson – Office of the National Coordinator

So, I can followup from my end. This is Michelle.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you. So, somebody in HIT Standards Committee might know this.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm sure they will.

Michelle Nelson – Office of the National Coordinator

Yes. I'll followup with David on this.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, it's Michael. For what it's worth, the I-MAGIC demo that you showed us during our .... meeting does have a bunch of under terms that might be relevant to family history.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We found that when we gathered detailed family history data about the patients, it changed the prevention recommendations for about 8% or 10%.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's great.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That's a reasonable number of people.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Everybody looks smarter.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, it's what you're supposed to do.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

The patients aren't getting these false positives.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. It's choosing wisely.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, we're saying to link it to those two outreach and CDS.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Then, what are we going to do with this one then? We have an opt-in question for HIT Standards. Then, what do we do with this particular one, move it to whatever standards? Well, maybe get the response back from HIT Standards and then figure out how to deal with this?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Because I'm trying to refine it now. This has got to get connected.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think I would be in favor of making it a core item, but with the linkage in place.

W

The other—for purposes of social history—I know there were some issues relative to wanting family history for care coordination but I hear that less. Maybe they mean population management. I don't know.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think they mean more social history, but I'm not sure. Like, what social supports do you have in place?

Okay. Let's move to the next one then. So, the next one is an interesting one, which is notes, and we asked for at least an electronic note for more than 30%of unique visits or hospital days, and this measure was not included in the NPRM.

They just asked for a comment. They are fairly widely used, but there are some providers who have not used them. I don't know that anybody knows what the current state of play is here.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think one of the issues is hospital. Is that true, Charlene? I don't think it says consistently use ....

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Absolutely not. In the hospital, most of them are still—they're transcribing. Voice is still emerging, but it's been emerging 30 years. So, in many cases, and I think what we heard at the one hearing is that vendors are so pushed, they're not putting—they have to put time into actually automate this piece to get it to work.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'd still be in favor of including it and maybe raising the threshold personally.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I was hoping—I'll be really honest in Stage Three, I was really hoping by Stage Three we could actually move the bar in terms of—the discharge summary is so important to pass on. We hear that all the time, to really make it electronic by Stage Three, to really raise the bar by Stage Three so that documentation is electronic by then. We start to move the bar on that discharge summary too.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But it's already electronic, right?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

After the fact.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Did you say discharge summary or discharge instructions?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Summary. I wanted to go for the whole thing.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

For discharge summary, I think we could ask for them all to be electronic.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But I wanted them so that they could make them available at the transition of care. So, that will—because that's what we hear out there. They need—from the long-term care community, all those communities need that chart summary like the same day.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But that's a human problem.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes. I know. I was just dreaming a little.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But you're right though. That clearly is affecting both the transition and the readmission.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, it is. At the long-term care hearing, they were really just talking about the need to—and if you think about it, if it's pre-populated with a lot of the data that's captured throughout the process and there's a short summary that gets generated before the patient's discharge, that would be wonderful and what's communicated.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, let's back up. The reason it has been such a challenge is that you've had to go—you, the doctor, had to go make sure the chart's got all assembled with all the stuff and went down in medical records and you had to make sure that you found the time when you're in the hospital to go down there, sign it, etc. So, that should not be the problem anymore. First of all, everything's already "assembled." ....

Two, you can do this anywhere and it is in your best interest for the accuracy of the record and your memory to get the stuff recorded anyway. So, shouldn't this almost be like the inventory because you just

aren't waiting for things anymore? That is a major contribution. We've been saying how hard it's been on paper. Yes, it has been hard, but let's set a new standard. ... summary.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, it's kind of for Stage Three, I thought.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, it's Michael. I still think you're going to face the human issues. So, you solved all the technology by compiling and everything. I'm not making any excuses, just trying to reflect what it's like—

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

No, I know it's not trivial.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But think about it, when we're ..., the time when you best can put it together and then how fast ... within the day because it just made sense

Michael Barr – American College of Physicians – Vice President, PA&I

I agree with you, Paul, but with the rotation of hours now and limitations, I'm just trying to think—it's not a technical issue. I absolutely agree with you. It's more of a cultural and human issue. So, I think driving this direction is definitely a good thing.

I just know that that's not as easy as it might sound if you just think about okay why don't you just dictate it because it also serves other purposes whereas all the information might be there and a quick note might suffice for transition, there are other reasons for the documentation such as medical, legal and some of the details that have to be put together. So, I'm not saying no. I'm just saying there are other things to really consider here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But maybe at least we could get that electronic note in for the transition, something. I still think we need to keep this on the list.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Can we shorten the time from indeterminate to four days, four calendar days?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think four days is too long.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I'm just trying to give Michael something. I agree. What if it were 48 hours?

Michael Barr – American College of Physicians – Vice President, PA&I

Don't have somewhere else where the actual summary gets sent right away?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No. Only right now we have the discharge instructions, and that I think is two business days.

Michael Barr – American College of Physicians – Vice President, PA&I

okay. So, do we want to make a discharge summary any less than that in terms of turnaround? I'm just saying that's a shorter, easier thing to put together and now were saying with this harder thing we should do less than two days?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, it's the most important thing for this transition.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes. They need it when the patient transitions.

Michael Barr – American College of Physicians – Vice President, PA&I

First thing—the one that's already there, in terms of the discharge summary..

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They have to have that stuff.

Michael Barr – American College of Physicians – Vice President, PA&I

I know the transition stuff. I'd be more in favor of moving that up and maybe the discharge summary sometime other than the day of discharge just to allow for the cultural thing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I was just typing at a minimum we could start to get it—it's automated now because it's for later but we really need to get the process in itself automated.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm totally with you, and I totally agree with David and Paul that this has to happen urgently. I'm just trying to think through the—

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...

Michael Barr – American College of Physicians – Vice President, PA&I

What we're asking.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, let's circle back. I'm hearing Charlene ask to add basically a new objective, which would be to generate the discharge summary electronically say within 24 hours for 90% of patients?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's the other thing, David.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I really think for patients who've just been discharged that that would be an achievable thing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is managing that population of patients that they've identified as high risk for readmissions and all those kind of things is where you want to focus on, right? This is not one that you can do just as part of your population because that's not fair, but on the other hand—

Michael Barr – American College of Physicians – Vice President, PA&I

But you could try to—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Actually, the models have nothing good to stratify.

Michael Barr – American College of Physicians – Vice President, PA&I

Has something perhaps as simple as somebody's transitioning to another facility or another care setting that should be less than 24 hours. That should be the same day to meet the use case that Charlene is talking about. If somebody is being discharged to home and has a follow-up with their primary care doctor, so two days is not as big a deal in that situation, but definitely when somebody is transitioning to another care setting, I could see a focus on that being what you all are pushing for, which is same day, you need to get that note done.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

There are plenty of reasons why the sick patients who are discharging from hospital could use good information but whoever needs to deal with that. I think Charlene has a really good point. This is one of the things that can significantly improve.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

this is one that we've been waiting for.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm not disagreeing at all.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We're with you.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm just saying in terms of where we want folks to focuses the high complex patient who's being transferred that they, the receiving facility should get that information that day, no built-in delay. Other's a slight delay, I know we're talking days more than a couple to allow for that workflow of cultural ... to take place.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, the ... comment is the predictive models have not been good, so we don't know—unless you're just saying some place that goes to yet another institution is the only important one.

Michael Barr – American College of Physicians – Vice President, PA&I

Exactly. I'm just focusing on a specific use case that Charlene is talking about where this patient is going to another level of care more acute or less acute but not going home. Somebody else is receiving that patient. They should get that information almost simultaneously with the transition.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, but I think you're disadvantaging an important group that we can help, the people were sending out on their own.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm not saying don't do it, but I'm saying that setting the expectation of a timeline is a little different. Again, just trying to take into account what the context is and what the challenges and operationalizing this is. If we're going to focus, the complex patient is moving onto another care setting where there are other folks who are going to be actively engaging in their care need that information at the time of transition. Somebody who's going home the next day is not going to be huge difference but will still have the impact you're looking for and whether somebody's going to another care facility or not is an easy triage decision. It's not any kind of stratification yes or no. It's a yes or no question.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Another way is to just have a percent and basically the individual is going to decide. It's easier and better just to do it all, just start the new habit, but if you wanted to get some leeway, maybe it's X percent, have the thing done within whatever it is, 24 or 48 hours because that's measurable and they won't have to worry about transition where it may not be indicated in the record.

Michael Barr – American College of Physicians – Vice President, PA&I

In all depends whether you want to get it broad or you want to focus early on. So, I can go either way, but I was responding to Charlene's particular case where they get information as they're leaving the hospital. There's no guarantee if you set a percentage of those are the ones that the practice or the hospital will focus on.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Do you really think they'd just ...?

Michael Barr – American College of Physicians – Vice President, PA&I

Is that a real question, David?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I was just trying to get the bar raised so that people start to focus on exactly what Paul said is that a lot of the automated and how do we finish and the discharge summary is one that we have from a policy perspective high-value. They needed it transitioned. That was kind of where I was trying to go with it at least for Stage Three.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, Michael, what could you live with around the discharge summary for Stage Three?

Michael Barr – American College of Physicians – Vice President, PA&I

It's not me who will live with it obviously. I'm just trying to project what other people.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

What do you think other people could live with?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is so hard. We haven't really asked about this one.

Michael Barr – American College of Physicians – Vice President, PA&I

To answer your question, I don't mean to be flippant with you, David, but I do think there might be an opportunity for folks to play this if it's not specified. If I'm a resident or house staff and I'm not trying to ... residents or house staff but faced with dictating 10% of the discharge or preparing 10% of the transitions or discharge summaries within 24 hours, the ones that are relatively less acute are going to be a lot easier to complete to get to the threshold.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So, what does that imply in terms of thresholds then?

Michael Barr – American College of Physicians – Vice President, PA&I

I think it this point, at least from my perspective, we're arguing about the timing. Should it be less than X number of days for everybody or whether it should be measured in hours for just a group of folks who are moving to another care facility as Charlene has posed and then have a slightly different standard for

everyone else. I understand, Paul, your concern. I completely hear you. I'm just trying to focus in on trying to get this started.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, you could you live with less than 24 hours if they're going to a long-term care facility?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Actually, the long-term care want it with the patient walking out the door. They want it same day.

Michael Barr – American College of Physicians – Vice President, PA&I

Any care facility, not just long-term care facility.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm with you. I'm just saying that group I was just talking to. They just talked about how valuable it was.

Michael Barr – American College of Physicians – Vice President, PA&I

... you would want that in their hands or actually the electronic should be flowing as they're leaving the hospital doors.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Is it well known where in the record, if and where people are going? I don't know that it's that well captured in the EHR.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

In some cases, I think—again, if the system has pretty good care coordination, but if they have good processes, they kind of know, but I think from my parent's experience, I don't know how they would ever know.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't think it's in the EHR, but I think the doctors only know.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They've got us in that transition record, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They've got to capture it somewhere at some point.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

They're just going to have to learn.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's sort of my point. One, record's may not even accommodate it, and two, the processes are probably not in place reliably to get it in there. So, it's a little hard to rely on that for Michael's measure.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But it is recorded where somebody's going. That is to say were they discharged to home or were they discharged to some other place. That's in there, right? You're required to submit that as part of the UB-92, kinds of things. Hello?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, we're here. If it's not in the EHR, sometimes it's in the registration system. That's all.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Let's go back to the notes and the records. I'm persuaded by what Paul said that this is still important.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Michael, comfortable with that?

Michael Barr – American College of Physicians – Vice President, PA&I

I think there's some good discussion to come from the future.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So, this was a useful discussion. The next one in Stage Two is the hospital sending labs, have patient providers for more than 40% of labs. In the NPRM, this wasn't included.

We reconfirmed this. It's one that I feel pretty strongly about. I would like to see the threshold raised in Stage Three. This is the easiest thing in terms of shipping data around.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think so many other things are going to depend on it. Everything's going to depend on this. So, if anything, what we're doing is we're helping out the rural practices because those are the ones that are struggling to get their hospital labs sent back to them.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Michael, are you comfortable with this one?

Michael Barr – American College of Physicians – Vice President, PA&I

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, maybe go with a higher threshold here, something like 70%. As we've gone along, we proposed—on the last part of our time, I'd like to basically go back and focus on things that go beyond any of these things. A couple of them of come up.

I think Charlene's suggestion around the discharge summary is a good one. We talked about with family history linking it to decision support and outreach. We talked about linking a couple of other things. We talked a bit about both having a dashboard and then the fact that the dashboard should be interactive and let you drill down.

Those are the kinds of things that I think will get us to the next level. When I think about this, my model for delivering better care is the first thing is just to get some decision-support to providers. We have some requests in about that. The second is having really good registry tools, but most vendors don't have those today and they aren't interactive in the way that we talked about and I think that we should spend some time making sure that we get the language right around that.

Then, the third thing is really tools to help your care coordinators and care managers interact with the really difficult patients because there are some that you just can't get out with either going to the doctor or just mailing them a postcard. You need a lot more intensive handling on that. But that's my own sort of mental model for improving quality.

Michael Barr – American College of Physicians – Vice President, PA&I

David, this is Michael. A question for you came up actually I was just in a Reliance Health Reform meeting about chronic care ... and cost. One of the speakers, Bruce Chernof from SCAN Foundation was talking about incorporation of functional status, patient functional status, as part of our efforts to improve quality. It's kind of weird that that's part of any of the Meaningful Use objectives and measures, and I'm not sure where it would fit if it's improved quality or it's engage patients and families, but I just tossed it out because it's something that was firmly believed by several folks in that audience.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure. That's a good point. We're doing a lot of stuff in this area. One term that allows people to use is PROM, Patient Reported Outcome Measures, and I'm really convinced that they will be important in the future, not too well worked out how best to collect them, how best to report them. Pretty clearly if we're going to get them, we have to use IT to do it. I'm not sure about what to say in the 2015 measures about that.

Michael Barr – American College of Physicians – Vice President, PA&I

That's why I raised it because I wasn't sure it's been talked about in the context of 2015. I haven't heard it talked about for Stage Two, and I don't know if there are even standards for collecting the information and it has implications obviously for collecting information in patients that we haven't really talked about very much.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't think there are standard so far. Now, which subgroup is dealing with the patient interaction stuff, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Christine Bechtel's, and they have started to talk about this.

Michael Barr – American College of Physicians – Vice President, PA&I

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

In fact, we have this hearing next week, on Friday. I don't know what the agenda is, but it includes—it is ... question about so let's say it's one thing to have like your pain or your functional status or even your ..., it's because you could imagine that would both inform people about yourself and the use in your treatment. It's another to have things that you'd want to be nonidentified like ... care where you'd want to contribute to an aggregate score without revealing your own identity. So, how do you capture this?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. Okay. Other thoughts about how we might go further, kind of go to the next level?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, we step back like we were doing and saying okay, remember we're on that third part of that arrow, which is to measure and improve outcomes and look towards the future way of taking care of patients which is at the population level as well as the individual level and what tools can we give providers that they don't have currently because we focus a lot on like the dashboard is one of the things that they don't have or more real-time measures of their own performance, as part of the dashboard, real-time feedback to the clinicians rather than sort of the ... is a year and 18 months late. Probably dovetails with the Quality Measure Workgroup which is what are the measures that are more engaging the providers. So, maybe on our side, it's making the tools available to providers in real-time. On the measure side, it's what are the better measures that align with ....

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That makes sense to me. Michael, do you have thoughts about this?

Michael Barr – American College of Physicians – Vice President, PA&I

I don't have anything to say other than I agree.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Charlene?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Mine was more—remember how back when we were I think in terms of I like the change. We're actually going to start to do the reporting on the medication errors, the other errors we talked about was the IV management and that type of thing because of the errors there. So, again, where we can start to actually report some of those things I think is a huge step and maybe we want to look at where we are relative to not only the medication administration but intravenous fluid administration too because that's a big source of issue.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I agree.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The other space would—and then this ties back to the measures, Paul, and maybe this links to categories of clinical decision support managing in sections and all that type of stuff. So I don't know where—can they link to certain—we're trying to reduce those infection rates and there's tons of work going on there too, but linking it together and starting to track and managing the populations is all important there.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Michelle, even in Stage One and also Stage Two we have some placeholders for Stage Three. Is that handy somewhere?

Michelle Nelson – Office of the National Coordinator

It'll take me a minute.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Not a problem. At this point while we're thinking about future ones, we want to make sure we didn't come up with the good ideas before.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Broadly, I feel like we made a lot of headway here and came up with a number of suggestions that will be—

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think that the course changed from kind of managing the acute care scenario to the chronic care scenario and diseases and population health.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. You need tools for both, but we really have to start moving on the population direction.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Going back to our overarching goals, we said align with emerging payment policies, harmonize qualifications or harmonizing it with the CMS program, support our population health, we talked about that a lot, improve health with HIT, don't penalize to excess, maybe would that apply to some of the things we've discussed is if we raise the bar too high then all of a sudden we may inadvertently hurt some of the focus we had before, which is on doing the right job rather than getting the right score, focus on real-time impact at the clinic care, patient partnership for the ... engaging patients group, emerging sources of data, ..., CDS and population health assessment to drive policymaking, health disparities stressed by race and ethnicity, measure as to what end is this happening.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

It seems to me like we did a pretty good job of going through this.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul, I just find that document. Do you want me to just quickly read off the items? So, for drug/drug and drug/allergy interactions, the goal was to have medical endorsements of EDI with higher positive clincal value and ability to record reasons for overriding lists for demographics low granular ... talked about. For our smoking status, add a new field for verification for second hand smoke. For advanced directives, signal ability to store and retrieve a copy of the current AD for history and record family history, centers ... appropriate standards. So, we had that conversation again today. I think that's everything for this group.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, I'm trying to look at what we did last time. So under smoking status, it says here our states should ensure being coated in a standard way or retire the objective.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Actually, didn't one of the responses coming back from the inquiry made the point that because it's captured on the measure, they actually recommended retiring it?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I see, rather than keep it as a ....

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They had to capture it to be able to report measures. So, they said well, I know there was one other one they suggested retiring because it was captured in the measure.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Remind me what the one that you just said was.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is smoking.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I would be okay with that. I'm trying to remember what the other one was.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I do too. I can't remember. I've probably got the letter ....

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We keep putting it in our parking lot and not necessarily the hearing about AD and states because that's what our note is to ourselves in terms of we keep wanting to at least make it core if not raise the percent and extend the ability to retrieve AD. We probably need to just more systematically explore what are the issues.

Another area that interestingly could be more implementable is Pulse because it is an order. So, unlike AD, which may go—you don't know where it's stored and how it's linked etc., a Pulse actually is the standing order. You could see how you could actually order that. Now, I don't how you keep it from one episode or encounter to another, but at least it's an order.

Michelle Nelson – Office of the National Coordinator

Paul, just so you know, the Patient and Family Engagement Team has talked about that as well.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, maybe we need to write a note to ourselves, Michelle, for scheduling that hearing.

Michelle Nelson – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We're essentially at the end of our time, but this has been very productive. Any last thoughts before we wrap up?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Do we have public comments?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

At this point, we have to do that. Shall we go to the public comments?

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the line for public comment?

Operator

We have no public comments at this time.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Thank you. So, thank you all.

W

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you, David.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Bye-bye.

Public Comment Received During the Meeting

1. SNOMED does support Family history for many high profile diagnosis i.e. breast cancer 1st degree female relative